Pediatric & laser DENTISTRY
Nick A. Prater, DDS, LLC

Today's Date_____

Child's First Name_____Child's Last Name_____Nickname_____M F

Child's Age_____Child's Date of Birth_____/_____/_____

Residence Address_____City_____State_____

Zip_____Residence Phone_____

Email Address_____(for appointment confirmation)

School_____Grade_____

Please list any special interest, favorite toys, movies, ect._____

1. **Who is accompanying the child today?**

Name_____Relation_____

Do you have legal custody of the child? Yes____No____

Parents Marital Status: Single___Married___Widowed___Divorced___Separated___

Whom may we thank for referring you?_____

2. **Mother's Information**

Stepmother___Guardian___

Name_____Date of Birth___/___/___

Wk/Cell #_____Home#_____

SS#_____

Present Employer_____

Father's Information

Stepfather___Guardian___

Name_____Date of Birth___/___/___

Wk/Cell #_____Home#_____

SS#_____

Present Employer_____

3. **Person Responsible for the Account**

Name_____Relation_____

Billing Address_____City_____State_____Zip_____

4. **Insurance Information**

Primary Insurance Company Name_____

Insurance Company Phone #_____

Claims Mailing Address_____City_____State_____Zip_____

Subscriber ID#(must have this information to file claim)_____

Group#_____

Policy Holder's Name_____Policy Holder's Date of Birth___/___/___

Policy Holder's Employer_____

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Patient's Name_____Date of Birth_____Today's Date_____

Medical Problems_____Heart disease_____Bleeding disorders_____Other_____

Male_____Female_____ Home birth_____Hospital birth_____Vaginal birth_____C-Section_____

Are you presently breastfeeding? YES____NO____ If no, how long since you stopped breastfeeding? _____

MEDICAL HISTORY: Has your child ever experienced any of the following problems or treatments?

1. Infants are usually given Vitamin K at birth to prevent bleeding in the first 8 weeks of life. Did you sign any waiver to refuse the administration of Vitamin K? YES____NO____
2. Was your infant premature? YES____NO____
3. Does your infant have any heart disease? YES____NO____
4. Has your infant had any surgery? YES____NO____
5. Is your infant taking any medications? Reflux____Thrush____Other____Name of medication_____
6. Has your infant experienced any of the following?

____Poor latch
____Falls asleep while attempting to latch
____Slides off nipple when attempting to latch
____Colic symptoms
____Reflux symptoms (due to excessive clicking and air intake)
____Poor weight gain
____Gumming or chewing of your nipple when nursing
____Unable to hold a pacifier in his/her mouth
____Short sleep episodes requiring feeding every 1-2 hours

____Gaging
____Hiccups
____Clicking
____Gassiness
____Waking up congested
____Snoring
____Heavy breathing
____Sleep apnea

7. Has your infant had a prior surgery to correct a tongue or lip tie? YES____NO____
   If yes, when and where?_____
8. Do you have any of the following signs or symptoms?
   ____Creased, flattened, or blanched nipples after nursing
   ____Blistered or cut nipples
   ____Severe pain when your infant attempts to latch
   ____Poor or incomplete drainage
   ____Infected nipples or breasts
   ____Plugged ducts or mastitis
   ____Nipple thrush

Birth Weight_____

Present Weight_____

Dr. Prater may administer acetaminophen on infants over 2 months prior to surgery.

Has your infant received any type of pain medication today?

YES____NO____

Is it okay to give your infant pain medication?
YES____NO____

Pediatrician _____Phone number_____

Address_____City_____State_____Zip_____

Lactation Consultant_____Phone number_____

Address_____City_____State_____Zip_____

Referred by_____Phone number_____

Address_____City_____State_____Zip_____

Did you use the internet to find our website? YES____NO____

Have you visited our website?

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CONSENT FOR EVALUATION

State Law requires us to obtain your consent for any contemplated dental treatment or oral surgery. However, prior to any treatment, it is necessary to perform a thorough clinical evaluation including any diagnostic aids necessary. Please read this and ask about anything you do not understand. We will be happy to explain anything in further detail.

I hereby authorize and direct Dr. Nick Prater and Dr. Breanna Prater to perform upon my child (or legal ward) a complete dental examination including the advisable radiographs (x-rays) and any other diagnostic aid deemed necessary by the Dentist in order to properly diagnose the dental condition of my child. I also understand that if any dental treatment is necessary, I will be required to sign consent for treatment after having been explained the proposed treatment.

GENERAL CONSENT FOR TREATMENT

State Law requires us to obtain your consent for contemplated dental treatment. This form serves as a general consent for dental treatment. Please read this form carefully and ask about anything you do not understand. We will be happy to explain anything in further detail.

1. After consultation with Dr. Nick Prater and/or Dr. Breanna Prater and an explanation about any proposed procedure, I hereby authorize and direct the treating Dentist and/or dental auxiliaries of his/her choice to perform upon my child (or legal ward) the following dental treatment or oral surgery procedure(s) including the necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids:
   In general terms the dental procedures **may include one or a combination** of the following:
   *Cleaning of the teeth and the application of topical fluoride
   *Application of plastic "sealants" to the grooves of the teeth
   *Treatment of diseased or injured teeth with dental restorations
   *Removal (extraction) of one or more teeth
   *Treatment of diseased or injured oral tissues (hard and/or soft)
   *Treatment of malposed (crooked) teeth and/or developmental abnormalities
   *Treatment of Orthodontia

2. Alternate methods of treatment, if any, will also be explained to me, as well as the advantages and disadvantages of each. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to the cure.

I hereby state that I have read and understand this consent, and that all questions about this consent or any planned procedures have or will be answered in a satisfactory manner prior to any treatment. I understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment. I further understand that this consent will remain in effect until such time that I choose to terminate it.

X_____ _____

Signature of parent or guardian

_____

Print name of parent or guardian

X_____

Signature of witness

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Welcome to the office of Dr. Nick Prater and Dr. Breanna Prater. We want to make your visit productive and enjoyable. We are happy to answer any and all questions regarding insurance plans and payment policies you may have.

I. FINANCIAL POLICY

1. Patients WITH insurance coverage:
   *Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you. However, you are responsible for understanding your individual benefits and for the payments of your account.
   *Regarding insurance plans where we are a participation provider, all co-pays and deductibles are **due prior or at the time of treatment.**
   *Regarding insurance plans where we are NOT a participating provider, estimates will be collected **prior to or at the time of treatment** and the difference will be billed as necessary.
   *If your insurance company has not paid the claim within 45 days, the balance will be automatically transferred to you.
   *In some cases, insurance carriers may pay for alternative benefits other than the treatment performed. In this case, you are responsible to pay for the difference.
   *Even if you have dual coverage there may still be a portion that is your responsibility.

2. Patients WITHOUT insurance coverage:

   *Patients without insurance coverage are required to pay for services rendered **at or prior to the time of treatment**.

II. CANCELLATION POLICY

*We require a 24 hour cancellation notice for a scheduled appointment.

*Patients who fail to show for their scheduled appointment without giving notice will be charged a $50.00 fee.

III. BILLING POLICY

*Checks returned unpaid from the bank are subject to a $35.00 service fee

*Accounts delinquent more than 45 days from the date of billing are subject to a 1% per month (12% annually) finance charge.

*When your bill is unpaid, a collection agency may be chosen to manage delinquent accounts. If your account is sent to our collection agency you will be responsible for collection and court costs along with attorney's fees.

BY SIGNING, I AGREE I HAVE READ AND UNDERSTAND PEDIATRIC & LASER DENTISTRY'S FINANCIAL POLICY, CANCELLATION POLICY, AND BILLING POLICY AND THAT I AM THE PERSON RESPONSIBLE FOR THIS PATIENT'S ACCOUNT.

_____ _____

Signature of parent or guardian Date

_____

Printed name of parent or guardian

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

*Obtain payment from third-party favors.

*Conduct normal healthcare operations such as quality assessments and physician's certification.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at their current address and obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient name: _____

Relationship to patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so, as documented below:

Date:_____Initials:_____

Reason:_____